Youth Suicide

Definition: All deaths among people 15 to 24 years of age due to intentional self-inflicted injuries. ICD-9 codes E950-E959.

Summary

There were 122 suicide deaths among 15-24 year-olds in Washington in 1994. The suicide death rate for this age group in 1994 was 17.2 per 100,000 population. The youth suicide death rate has been fairly stable for the past 15 years. The suicide attempt rate among youth is showing signs of decline. There is currently strong state and community emphasis on youth suicide prevention programs. There is a good chance that Washington will meet or exceed its year 2000 youth suicide reduction goals.

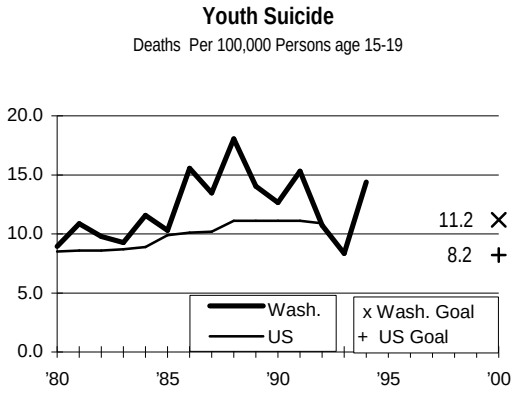
Time Trends

From 1980 through 1994, suicide rates among Washington youth age 15-19 ranged from a low of 12.7 per 100,000 in 1982 to a high of 17.8 in 1987. In 1994, the rate was 17.2 per 100,000. The chart below shows this smaller age group because there is a corresponding national year 2000 goal and the national data are readily available for comparison.

In the larger 15-24 year old age group, and in the entire state population as a whole, suicide death rates have been fairly stable, with no evidence of a significant upward or downward trend. There was, however, a significant decline in nonfatal suicide *attempts* resulting in hospitalizations among 15 to 24 year olds. The rate declined from 121 per 100,000 in 1989 to 108 per 100,000 in 1994.

Year 2000 Goal

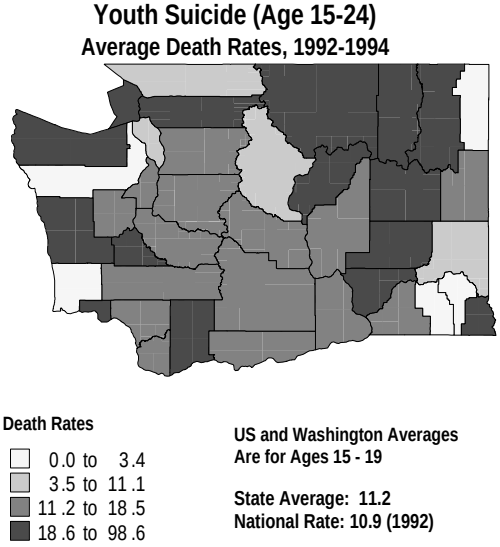
Washington has two youth suicide goals for the year 2000—one for 15-19 year-olds (11.2 per 100,000) and another for 20-24 year-olds (18.6 per 100,000). The 1992-94 average rate for suicide among 15-19 year-olds in Washington was 11.2, so we have met that goal, at least for the recent past. The 1992-94 rate for 20-24 year-olds was 19.2 per 100,000. Given the current emphasis on prevention programs to reduce youth suicide, and the progress noted in reduction of hospitalized suicide attempts during the past few years, it is reasonable to expect that we will meet or exceed the year 2000 youth suicide reduction goals for both age groups.



Geographic Variation

The map below shows 1992-94 average youth suicide death rates by county. It is important to note that for many counties the rates are based on very small numbers and are subject to considerable year-to-year fluctuation. People interested in assessing youth suicide at the local level, and comparing the experience of various areas of the state, would be well advised to examine several years of youth suicide deaths in conjunction with data on nonfatal hospitalized suicide attempts.

Historically, Washington's youth suicide and overall suicide rates have been higher than national rates. This continues to be true. In 1992, the most recent year for which national data are available, the national suicide rates for 15-19 year-olds and



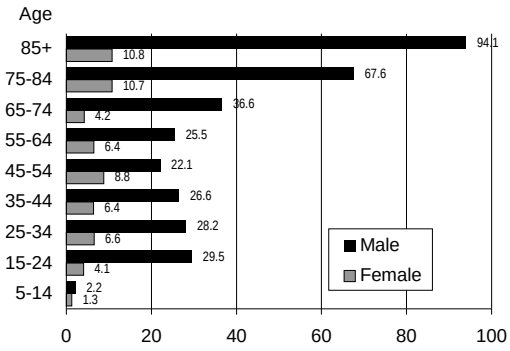
20-24 year-olds were 10.8 and 14.9, respectively. Washington's 1992-1994 suicide rate for 15-19 year-olds was 11.2, and the rate for 20-24 year-olds was 19.2 per 100,000. We do not know what accounts for these higher rates in Washington. Research has shown a strong association between suicide rates and availability of firearms in the home. [1] Additional research might help determine whether such availability is particularly high in Washington.

Age and Gender

Males in the 65 and older age groups have the highest suicide death rates. Suicide rates are relatively low for 15-24 year-olds. The number of suicide deaths in this age group accounted for only 16% of all suicide deaths in the state in 1994.

The significance of the youth suicide problem becomes more evident when we examine rates for hospitalized suicide attempts combined with suicide death rates—15-24 year-olds have by far the highest combined rate.

Suicide
by Age and Gender
Age-Specific Deaths per 100,000, Wash. State, 1994

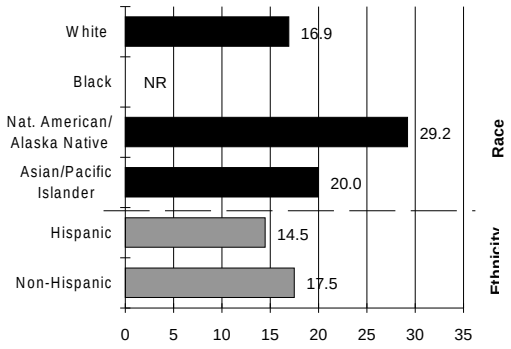


The suicide death rate for males 15-24 years of age in 1994 was more than seven times higher than the rate for their female counterparts (30.0 per 100,000 for males compared to 4.1 for females). Females, however, had a much higher nonfatal hospitalized suicide attempt rate (143.5 per 10,000 for females compared to 74.7 for males).

Race and Ethnicity

Historically, youth suicide rates have been highest for Native Americans and whites, followed by Blacks and Asian/Pacific Islanders. Annual counts by race group are small for all groups except whites. In 1994 the youth suicide rate for Asians was particularly high. There were 10 Asian youth suicides in that year, producing a rate of 20 per 100,000 population, exceeded only by the rate of 29 for Native Americans. The high rate for 1994 suggested that Asian youth suicides rates warrant monitoring, but data from 1980-1994 show no evidence of a significant upward trend

Youth Suicide
by Race and Ethnicity
Deaths per 100,000,
Persons age 15-24, Wash. State, 1994



Other Measures of Impact and Burden

Premature mortality. In Washington, suicide is the second leading cause of death for youth 15-24 years of age, accounting for 21% of deaths in 1994. The only cause of more deaths in this age group is unintentional injury (primarily motor vehicle deaths). While suicide death rates in other age groups are comparable or even higher, these deaths among young people are particularly damaging, not just to the person who dies, but to surviving friends and families; they result in a disporportionate number of years of life lost, and they are in many cases preventable.

Hospitalized attempts. As previously noted, nonfatal hospitalized attempts outnumber suicide deaths among youth by about seven to one. Nonfatal suicide attempts often result in significant medical, emotional and economic costs.

Risk and Protective Factors

Experts in the field agree that there is no single cause or predictor of suicidal behavior among youth. Factors known to increase risk or serve as indicators of potential risk fall into three categories:

Direct factors. These are factors known to be most strongly associated with suicidal behavior. They include:

- A prior suicide attempt (the strongest predictor of suicide).
- Suicide ideation and threats of suicide.
- Homicidal ideation.
- Exposure to suicide.
- Suicide of a family member of friend.
- Detailed intentions for a suicide attempt (e.g., plan of when, where, how)
- Access to lethal means, especially a gun.

Related factors. These are factors that while not as clearly linked to suicidal behaviors are closely associated with increased suicide potential among youth. These factors appear to intensify a youth's vulnerability to thoughts of self-harm. Included in this group are:

- Serious depression lasting longer than two weeks.
- School performance problems, likelihood of school dropout.
- Serious family fights and conflicts.
- Use and abuse of alcohol and other drugs
- Isolation, alienation from family and peers.
- A high number or accumulation of serious stressful events, transitions, or losses.
- Involvement in risky behaviors including driving recklessly or while intoxicated.

Precipitating factors. These are events that immediately precede a suicidal act and seem to initiate or cause the suicidal behavior in a vulnerable youth.

- Opportunity, including access to a gun or other lethal means and inadequate supervision.
- Altered states of mind including hopelessness, rage, and intoxication.
- Undesirable life events such as disrupted interpersonal relationships, loss or death of a friend, loss of self-esteem, unintended pregnancy, physical or sexual abuse.

Factors which serve to protect, buffer and support youth who may be at risk for suicide have been identified. Two types of protective factors appear to be most important:

Social resources. These include community, family, and friendships. Important social resources include:

- Strong interpersonal bonds, particularly with family members or other caring adults;
- Available social support resources at home and at school;
- Dominant attitudes and values prohibiting suicide, including religious values and strong beliefs in the meaning of life.

Personal resources. Personal resources found to be significantly linked with lower suicide potential include:

- Strong sense of self-worth and high self esteem;
- Decision-making skills and a repertoire of positive, health-promoting coping strategies;
- A sense of personal control and a variety of skills to manage stress, depression, and anger.

High Risk Groups

Gender differences. Males account for the greater proportion of completed suicides, whereas, females account for the greater proportion of suicide attempts. In Washington the ratio of male to female suicides is approximately 4:1. In contrast the ratio of male to female suicide attempts is approximately 1:2.

Race/ethnicity. In Washington state and nationally, suicide rates tend to be highest for Whites and Native Americans.

Youth with emotional or behavioral disorders. Young people at high risk for suicide include those who are depressed, aggressive, impulsive, ultra perfectionist, have rigid behavioral patterns, or abuse drugs.

Intervention Points, Strategies and Effectiveness

Youth suicide is a very complex problem requiring the involvement and cooperation of people in the mental health system, the social service system, the education system, the personal health care system, and the public health system.

Youth suicide prevention points and strategies fall into three groups, each directed toward different segments of communities.

Universal approaches. Universal prevention approaches are designed to reach primarily youth 15-24 years of age, their parents and other adults. Community exposure is expected to be high, reaching 85% or more of the youth and adults in our communities. Included under universal prevention are such approaches as public education campaigns on suicide prevention; school-based educational campaigns for youth and

parents; public educational campaigns to restrict access to lethal means of suicide.

Selective approaches. Selective prevention approaches focus on high risk populations. These efforts are carried out by citizens trained to be prevention agents or "gatekeepers." They are expected to impact 25% to 30% of all youth who are at high risk for suicide and suicidal behaviors by providing these youth with immediate crisis intervention and indicated prevention as necessary. Included under selective prevention are such approaches as screening programs with special populations, gatekeeper training, statewide crisis hot-lines, consultation, education, and crisis intervention services.

Indicated approaches. Indicated prevention approaches are designed for youth at highest risk for suicide, estimated to be between 10% and 15% of all youth in Washington. They include skill-building support groups and family support groups. Although directed toward youth the interventions will serve them beyond their immediate situation and into adulthood.

Prevention effectiveness. There is a growing body of scientific evidence which suggests that using combinations of the three approaches described above, particularly when aimed at high risk youth, can serve to reduce the rates of suicide and suicide behaviors. Some examples of intervention strategies and approaches which are showing promise include:

- *Gatekeeper training.* This training provides adult front-line caregivers with competencies to recognize risk factors associated with suicide, screen high risk youth, communicate with youth at high risk for suicide, and make referrals to appropriate services. Two programs with demonstrated efficacy are Living Works and Emergency Room Staff Training for Adolescent Suicide Attempters.

- *Public education on limiting lethal means.* Firearms are the leading method used in the completion of suicide in Washington state. Studies have linked higher suicide rates to easy firearms access. Broad public dissemination of information about safe storage and handling of firearms, through the media and other channels, holds promise for reducing suicide rates.

- *Support/skill-building groups.* These activities provide a safe and comfortable environment in which vulnerable youth can learn and practice life skills effective for reducing suicide-risk factors and enhancing protective factors. Three tested programs for reducing suicide potential are: courses in coping with depression, personal growth classes, and group problem-solving/support interventions.

The Youth Suicide Prevention Plan for Washington State describes a number of other strategies which show promise in reducing the incidence of youth suicide and suicidal behaviors.

Data Sources

State suicide death data: Washington Department of Health, Center for Health Statistics. Prepared by DOH Injury Prevention Program.

State nonfatal hospitalized suicide attempt data: Washington Department of Health, Hospital and Patient Data. Prepared by DOH Injury Prevention Program.

National suicide death data: National Center for Health Statistics

For More Information

Department of Health Injury Prevention Program. Telephone: (360) 586-5693

Washington Department of Health. Youth Suicide Prevention Plan for Washington State. January, 1995.

Centers for Disease Control. Youth Suicide Prevention Programs: A Resource Guide. 1992.

Technical Notes

Race and ethnicity: See technical appendix

Because of the social stigma associated with suicide and a lack of uniform criteria used by coroners and medical personnel, it is widely accepted that suicide death rates and rates of hospitalization for suicide attempts are greatly underestimated Endnotes

Endnotes:

[1] Kellermann AL, Rivara FP, Somes G, Reay DT, Francisco J, Banton JG, Prodzinski J, Fligner C, Hackmann BB. Suicide in the home in relation to gun ownership. N Engl J Med 1992; 327:467-472.